MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8395

CERTIFICATE OF DEATH

08373

Reg. Dist. No. 20

1. PLACE OF DEATH
- a. COUNTY: Kent — MARYLAND
- b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chestertown
- c. LENGTH OF STAY IN 1b: 8 hrs
- d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Kent + Queen Annes Hosp.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
- a. STATE: Maryland
- b. COUNTY: Queen Anne's
- c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Millington
- d. STREET ADDRESS: ---
- e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) — First: Baby — Middle: Boy — Last: Atkinson

4. DATE OF DEATH — Month: August — Day: 7 — Year: 1956

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: August 7, 1956

9. AGE (In years last birthday) yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours 8 / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? America

13. FATHER'S NAME: Alvin Brown Atkinson

14. MOTHER'S MAIDEN NAME: Mae Vivian Holliday

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Mother — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
- IMMEDIATE CAUSE (a): Congenital debility
- DUE TO (b): Prematurity
- DUE TO (c):

773.5

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year 19 — Hour a. m. p. m.

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I **certify** that I attended the deceased from Aug 7, 1956, to ________, 19____, that I last saw the deceased alive on Aug 7, 1956, and that death occurred at 12 4 M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Geza Koralewski M.D. — ADDRESS (Street, city or town, state): Millington Md. — DATE SIGNED: 8.7.56.

PHYSICIAN'S NAME (Type): GEZA KORALEWSKI

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Aug. 9, 1956

22c. NAME OF CEMETERY OR CREMATORY: Wesley Chapel Cem.

22d. LOCATION (City, town, or county): Rock Hall — (State): Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Edward Fellows — ADDRESS: Millington Md.

24a. REC'D BY REGISTRAR DATE: AUG 13 1956

24b. REGISTRAR'S SIGNATURE: Clara Barnes

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be released by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

2072 17XVI

MARYLAND STATE DEPARTMENT OF HEALTH--BALTIMORE, 18

8396 **CERTIFICATE OF DEATH**

08374

Reg. Dist. No. 202

1. PLACE OF DEATH
a. COUNTY: Kent — MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland b. COUNTY: Kent

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chestertown
c. LENGTH OF STAY IN 1b: life
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chestertown

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 123 Washington Ave.
d. STREET ADDRESS: 123 Washington Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Marian Middle: Josephine Last: Lusby Bowers
4. DATE OF DEATH: Month: Aug. Day: 31, Year: 1956 19

5. SEX: female
6. COLOR OR RACE: white
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Feb. 14, 1872
9. AGE (In years last birthday): 84 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Kent CO. Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Josiah Lusby
14. MOTHER'S MAIDEN NAME: Emily Usilton

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: no
17. INFORMANT: Miss. Mary Nicholson Address: Chestertown, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Carcinomatosis — INTERVAL BETWEEN ONSET AND DEATH: 1½ years

DUE TO (b): Carcinoma of sigmoid and — Both longer than 1/2 year

DUE TO (c): Carcinoma of breast

1948

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Jan 1955 to 8/31 1956 that I last saw the deceased alive on 8/31 1956, and that death occurred at 11:30 A.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: [signature] M.D.
ADDRESS (Street, city or town, state):
DATE SIGNED: 8/31/56

PHYSICIAN'S NAME (Type): Robert W. Farr - Chestertown, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Sept. 2, 1956
22c. NAME OF CEMETERY OR CREMATORY: Chester Cemetery
22d. LOCATION (City, town, or county) (State): Chestertown, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: J. Willis Wells ADDRESS: Chestertown, Md.
24a. REC'D BY REGISTRAR DATE: Sept. 4-1956
24b. REGISTRAR'S SIGNATURE: Clara S. Barnes

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS AIS (4)
ISM 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8397

CERTIFICATE OF DEATH

08375

Reg. Dist. No. 202

1. PLACE OF DEATH
a. COUNTY: KENT — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CHESTERTOWN
c. LENGTH OF STAY IN 1b: 7 DAYS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: KENT + QUEEN ANNE'S

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: MD. — b. COUNTY: QUEEN ANNE'S
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BARCLAY
d. STREET ADDRESS: None
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First: GEORGE — Middle: SPENCER — Last: BROWN

4. DATE OF DEATH: Month: AUG — Day: 24 — Year: 1956

5. SEX: M

6. COLOR OR RACE: COL

7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [X]

8. DATE OF BIRTH: JAN 30, 1879

9. AGE (In years last birthday): 77 yrs.

IF UNDER 1 YEAR: Months: — Days: — IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): FARM LABORER

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (State or foreign country): Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: BILLY SIMMONS

14. MOTHER'S MAIDEN NAME: MARY GARRISON.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): UNK — (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: None

17. INFORMANT — Address: HOSPITAL CHART.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): UREMIA — INTERVAL BETWEEN ONSET AND DEATH: 1 WEEK
DUE TO
(b): GENERALIZED CARCINOMATOSIS (PRIMARY SITE UNKNOWN).
DUE TO
(c):

199.9

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour: — o. m. / p. m. — Month: — Day: — Year: 19

20d. INJURY OCCURRED: While at work [ ] Not while at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from AUG 20, 1956, to AUG 24, 1956, that I last saw the deceased alive on AUG 24, 1956, and that death occurred at 11:30 PM, from the causes and on the date stated above.

ACTUAL SIGNATURE: Arthur T. Keefe, Jr. M.D. — ADDRESS (Street, city or town, state): CHESTERTOWN, MD — DATE SIGNED: 8.29.56

PHYSICIAN'S NAME (Type): ARTHUR T. KEEFE, JR. MD

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 22b. DATE THEREOF: 8/29/56 — 22c. NAME OF CEMETERY OR CREMATORY: Barclay — 22d. LOCATION (City, town, or county) (State): Barclay Md.

23. FUNERAL DIRECTOR'S SIGNATURE: J. E. Boulais — ADDRESS: Greensboro, Md

24a. REC'D BY REGISTRAR — DATE: Aug 27-56 — 24b. REGISTRAR'S SIGNATURE: Clara L. Barnes.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

68376
Reg. Dist. No. 502

1. PLACE OF DEATH
a. COUNTY 8398 Kent MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown
c. LENGTH OF STAY IN 1b 12 years
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Calvert St.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Kent
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown 37
d. STREET ADDRESS Calvert St. 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First: Jean Middle: Last: Brown
4. DATE OF DEATH Month: Aug. Day: 25, Year: 1956 19

5. SEX	6. COLOR OR RACE	7. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
female	colored	NEVER MARRIED ☒	Feb. 17, 1937	19 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housework		Queen Anne Co. Maryland	USA

13. FATHER'S NAME: Charles Brown
14. MOTHER'S MAIDEN NAME: Martha May Sparks

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	Address
no	no	Charles Brown	Calvert St. Chestertown, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bullet wounds in the abdomen with damage — INTERVAL BETWEEN ONSET AND DEATH: few minutes
DUE TO to kidney, liver and hemorrhage
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b)
DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) — 19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Shot by James Wilson in his home in Chestertown

20c. TIME OF INJURY Hour a. m. p. m.	Month, Day, Year	20d. INJURY OCCURRED While at work ☐ Not while at work ☒	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
	8/25 1956		Calvert St.	Chestertown	Kent	Md.

21. I certify that I took charge of the remains described above, held on Autopsy ☒ Inspection ☐, Inquiry ☐, and find that death resulted from: Natural causes ☐, Accident ☐, Suicide ☐, Homicide ☒ Undetermined cause ☐.

ACTUAL SIGNATURE Robert W. Farr M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED Aug. 27, 1956
EXAMINER'S NAME (Type) Robert W. Farr

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Burial	Aug. 29, 1956	Rich Neck Ball Cem.	near Church Hill Maryland

23. FUNERAL DIRECTOR'S SIGNATURE J. Willis Wells ADDRESS Chestertown, Md.
24a. REC'D BY REGISTRAR Aug. 29-56
24b. REGISTRAR'S SIGNATURE Clara L. Barnes

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to Chief Medical Examiner's Office along with form PHA3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 18 Film G202 9-14-56 ams 8407

68377

CERTIFICATE OF DEATH

Reg. Dist. No. 203

1. PLACE OF DEATH
a. COUNTY: Kent — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rock Hall
c. LENGTH OF STAY IN 1b: life
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Piney Neck

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Kent
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rock Hall
d. STREET ADDRESS: Piney Neck
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒ X

3. NAME OF DECEASED (Type or print): First MARY Middle ANNA Last COTTON

4. DATE OF DEATH: Month Aug.31 Day Year 1956

5. SEX: F
6. COLOR OR RACE: C
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Oct.19,1880
9. AGE (In years last birthday): 75 yrs.
IF UNDER 1 YEAR: Months ___ Days ___
IF UNDER 24 HRS.: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housekeeping
10b. KIND OF BUSINESS OR INDUSTRY: home
11. BIRTHPLACE (State or foreign country): Rock Hall, Md.
12. CITIZEN OF WHAT COUNTRY? u.s.a.

13. FATHER'S NAME: William Tilghman
14. MOTHER'S MAIDEN NAME: Sarah Saunders

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service): ----
16. SOCIAL SECURITY NO.: 220-03-4430
17. INFORMANT: Address: Mrs. Geneva Sisco, Rock Hall, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) [illegible] — INTERVAL BETWEEN ONSET AND DEATH
002x
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b) [illegible] — Unknown
DUE TO (c) [illegible]

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
Massive pulmonary hemorrhage due to chronic pulmonary tuberculosis

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Aug 20, 1956, to Aug 31, 1956, that I last saw the deceased alive on Aug 29, 1956, and that death occurred at 7:45 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Norbet C Nitch M.D.
ADDRESS (Street, city or town, state): Rock Hall Md
DATE SIGNED
PHYSICIAN'S NAME (Type): Norbet C. Nitch M.D.
Rock Hall, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Sept.3/56
22c. NAME OF CEMETERY OR CREMATORY: Edsville Cemetery
22d. LOCATION (City, town, or county) (State): Rock Hall, Md

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Marvin V. Williams, Chestertown, Md.
24a. RECD BY REGISTRAR DATE: Sept 3/56
24b. REGISTRAR'S SIGNATURE: S. Sherwood Bowers

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

68378

8399

CERTIFICATE OF DEATH

Reg. Dist. No. 201

1. PLACE OF DEATH
a. COUNTY: Kent — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chestertown
c. LENGTH OF STAY IN 1b: 8 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: [illegible]

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Kent
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Betterton
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Eva — Middle: — Last: Davis

4. DATE OF DEATH: Month: August — Day: 3 — Year: 19 56

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Nov. 2, 1884
9. AGE (In years last birthday): 72 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Samuel T. Bassett
14. MOTHER'S MAIDEN NAME: Brown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.: NONE
17. INFORMANT — Address: Hosp. records Chestertown, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Congestive heart failure — INTERVAL BETWEEN ONSET AND DEATH: 8 days

4442X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Myocarditis — 1 year.
DUE TO (c): Cardiovascular renal disease — 1 year ?

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Obesity

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a. m. / p. m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 7-27, 1956, to 8-3, 1956, that I last saw the deceased alive on 8-3, 1956, and that death occurred at 2:10 M, from the causes and on the date stated above.

ACTUAL SIGNATURE: A.C. Dick M.D. — ADDRESS (Street, city or town, state): Chestertown, Md. — DATE SIGNED: 8-3-56

NAME (Type): A.C. Dick

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 8-6-56
22c. NAME OF CEMETERY OR CREMATORY: PARKWOOD CEMTY
22d. LOCATION (City, town, or county) (State): BALTIMORE MD.

23. FUNERAL DIRECTOR'S SIGNATURE: Victor N. Kennedy — ADDRESS: STILL POND, MD.
24a. REC'D BY REGISTRAR DATE: 8/4/56
24b. REGISTRAR'S SIGNATURE: E Kennard Jones

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

68379

CERTIFICATE OF DEATH

8408

Reg. Dist. No. 2102

1. PLACE OF DEATH
a. COUNTY Kent — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) [illegible]
c. LENGTH OF STAY IN 1b: Life
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION [illegible]

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE [illegible] b. COUNTY [illegible]
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Worton
d. STREET ADDRESS: orton Point
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First [illegible] Middle ilton Last Powell
4. DATE OF DEATH: Month [illegible] Day [illegible] Year 19

5. SEX: [illegible]
6. COLOR OR RACE: ite
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: May 4, 1894
9. AGE (In years last birthday): 62 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer
10b. KIND OF BUSINESS OR INDUSTRY: [illegible]umer
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? [illegible]

13. FATHER'S NAME: [illegible]
14. MOTHER'S MAIDEN NAME: [illegible]

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: no
17. INFORMANT: Mrs. Katie Fo[illegible]well Address [illegible]

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Lobar pneumonia	1 week
DUE TO		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)	Progressive spinal muscular atrophy	4 years
DUE TO (c)		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Hypertensive Vascular disease

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from April, 19 56, to Aug. 25, 19 56, that I last saw the deceased alive on August 24, 19 56, and that death occurred at 10 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Willard F. Smith M.D. ADDRESS (Street, city or town, state): [illegible] DATE SIGNED: [illegible]

PHYSICIAN'S NAME (Type): Willard F. Smith Rock [illegible]

22a. BURIAL, CREMATION, REMOVAL (Specify): [illegible]
22b. DATE THEREOF: [illegible]
22c. NAME OF CEMETERY OR CREMATORY: [illegible]le, [illegible]
22d. LOCATION (City, town, or county) (State): [illegible]

23. FUNERAL DIRECTOR'S SIGNATURE: Willis Wells ADDRESS: [illegible]
24a. REC'D BY REGISTRAR DATE: 9-29-56
24b. REGISTRAR'S SIGNATURE: Clara L. Barnes

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 2, See: Birth Cert.

8400

CERTIFICATE OF DEATH

08380

Reg Dist. No. 2021

1. PLACE OF DEATH
a. COUNTY: Kent
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chestertown
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Kent & Queen Anne's Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Queen Anne's
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Infant Church Hill
d. STREET ADDRESS: ----
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First Ernest Middle Gary Last GEORGE

4. DATE OF DEATH: Month August Day 31 Year 1956

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 8/28/56
9. AGE (In years last birthday) yrs
IF UNDER 1 YEAR: Months Days 3
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Ernest Edward George
14. MOTHER'S MAIDEN NAME: Ellen Margaret Reid

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Prematurity (32 weeks) — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO

(c)

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Intrapartum anoxia, due to premature placenta separation

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from ____, 19__, to 8-31, 1956, that I last saw the deceased alive on 8/31, 1956, and that death occurred at 2:05 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Robert Wiehar M.D.
ADDRESS (Street, city or town, state): Chestertown, Md.
DATE SIGNED: 8/31/56

PHYSICIAN'S NAME (Type): ROBERT WIEHAR

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Sept. 1/56
22c. NAME OF CEMETERY OR CREMATORY: Church Hill
22d. LOCATION (City, town, or county) (State): Church Hill Md

23. FUNERAL DIRECTOR'S SIGNATURE: Marion V. Williams
ADDRESS: Chestertown Md.

24a. REC'D BY REGISTRAR DATE: Sept. 4-1956
24b. REGISTRAR'S SIGNATURE: Ciara S. Barnes

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/55

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8401

CERTIFICATE OF DEATH

18382

Reg. Dist. No. 202

1. PLACE OF DEATH
a. COUNTY: KENT — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CHESTERTOWN
c. LENGTH OF STAY IN 1b: 1 WEEK
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: KENT & QUEEN ANNE'S HOSP

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND b. COUNTY: KENT
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): LOCUST GROVE
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First WILLIAM Middle Last HENDERSON

4. DATE OF DEATH: Month AUG Day 24 Year 1956

5. SEX: MAL

6. COLOR OR RACE: COL

7. MARRIED [ ] NEVER MARRIED [X] WIDOWED [ ] DIVORCED [ ]

8. DATE OF BIRTH: MAY 2, 1908

9. AGE (In years last birthday): 48 yrs. IF UNDER 1 YEAR: Months / Days; IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): FARM-HAND

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): VIRGINIA

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: WILL HENDERSON

14. MOTHER'S MAIDEN NAME: LIZZIE HANDCOCK

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): UNK (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 213-11-7111

17. INFORMANT Address: HOSPITAL CHART

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): POST OPERATIVE SHOCK — INTERVAL BETWEEN ONSET AND DEATH: 48 HRS

DUE TO (b): INTESTINAL OBSTRUCTION

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c): PERFORATED DUODENAL ULCER

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month Day Year 19

20d. INJURY OCCURRED While at work [ ] Not while at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from AUG 16, 1956, to AUG 24, 1956, that I last saw the deceased alive on AUG 24, 1956, and that death occurred at 6:15 AM, from the causes and on the date stated above.

ACTUAL SIGNATURE: Arthur T. Keffe M.D. ADDRESS (Street, city or town, state): CHESTERTOWN, Md DATE SIGNED: 8/27/56

PHYSICIAN'S NAME (Type): ARTHUR T. KEFFE JR. M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): burial

22b. DATE THEREOF: 8/30/1956

22c. NAME OF CEMETERY OR CREMATORY: Janes Cem.

22d. LOCATION (City, town, or county) (State): Chestertown, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: J. Willis Wells ADDRESS: Chestertown, Md.

24a. REC'D BY REGISTRAR DATE: Aug. 27-56

24b. REGISTRAR'S SIGNATURE: Claud L. Barnes

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8409

68383

CERTIFICATE OF DEATH

Reg. Dist. No. 203

1. PLACE OF DEATH
a. COUNTY: KENT — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ROCK HALL
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: KENT
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ROCK HALL
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First NELLIE Middle GRANT Last HOGANS
4. DATE OF DEATH: Month AUG. Day 6 Year 1956
5. SEX: FEM.
6. COLOR OR RACE: WHITE
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 9-2-1875
9. AGE (In years last birthday): 80 yrs
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: DANIEL WEBSTER AIRES
14. MOTHER'S MAIDEN NAME: MARY L. LLOYD

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: MRS. MARY BEEKMAN — Address: Rock Hall Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Peritonitis, of unknown etiology — INTERVAL BETWEEN ONSET AND DEATH: 1 week
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b):
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Arteriosclerosis, Bronchitis, Congestive heart failure
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. p. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that I attended the deceased from Jan 1, 19 56, to Aug 6, 19 56, that I last saw the deceased alive on Aug 6, 19 56, and that death occurred at 6 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: Willard F Smith M.D. — ADDRESS (Street, city or town, state): Rock Hall, Md. — DATE SIGNED: 8/7/56
PHYSICIAN'S NAME (Type): WILLARD F. SMITH

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: AUG. 9
22c. NAME OF CEMETERY OR CREMATORY: WESLEY CHAPEL
22d. LOCATION (City, town, or county) (State): ROCK HALL MD.

23. FUNERAL DIRECTOR'S SIGNATURE: Edgar L. Lane — ADDRESS: Church Hill, Md
24a. REC'D BY REGISTRAR DATE: 8/9/56
24b. REGISTRAR'S SIGNATURE: S Elwood Burgess

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08384

8410

CERTIFICATE OF DEATH

Reg. Dist. No. 200

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/55

1. PLACE OF DEATH a. COUNTY: KENT — MARYLAND	2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE: MD. b. COUNTY: KENT
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): MILLINGTON — c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): MILLINGTON
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION	d. STREET ADDRESS — e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print)	First: MARY	Middle: T.	Last: JARMEN	4. DATE OF DEATH	Month: AUG.	Day: 14	Year: 19 56
5. SEX: F.	6. COLOR OR RACE: W.	7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	8. DATE OF BIRTH: AUG. 25, 1875	9. AGE (In years last birthday): 80 yrs.	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS: Hours / Min	

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE	10b. KIND OF BUSINESS OR INDUSTRY: HOUSEWORK	11. BIRTHPLACE (State or foreign country): MD.	12. CITIZEN OF WHAT COUNTRY?: U. S. A.
13. FATHER'S NAME: ROBERT THOMPSON	14. MOTHER'S MAIDEN NAME: unknown		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.: —	17. INFORMANT: Leonard Robinson	Address: Millington Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Stroke	13 days
DUE TO (b)	Gen. Arteriosclerosis	10 Years
DUE TO (c)		

331X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) —

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19	20d. INJURY OCCURRED White at work ☐ Not white at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County) (State)

21. I certify that I attended the deceased from Dec 6, 19 55 to Aug 19, 19 56 that I last saw the deceased alive on Aug 15, 19 56, and that death occurred at 12 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: H. H. Hamilton M.D. — ADDRESS (Street, city or town, state): Millington Md — DATE SIGNED: 8/23/56

PHYSICIAN'S NAME (Type): H. H. HAMILTON

22a. BURIAL, CREMATION, REMOVAL, (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)		
BURIAL	8/24/56	CRUMPTON CEM.	CRUMPTON, Q. A. Co. MD.		
23. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS	24a. REC'D BY REGISTRAR DATE	24b. REGISTRAR'S SIGNATURE		
Edward Fellows.	Millington Md.	8/27/56	Elz. Mulford		

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08385

CERTIFICATE OF DEATH

8402

Reg. Dist. No. 203

1. PLACE OF DEATH
a. COUNTY Kent
MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Kent

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown
c. LENGTH OF STAY IN 1b years
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION [illegible] Tolchester
d. STREET ADDRESS [illegible] Tolchester
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print) First Clara Middle [illegible] Last [illegible]rnet
4. DATE OF DEATH Month August Day 24 Year 1956

5. SEX [illegible]le
6. COLOR OR RACE white
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH Dec. 25, 1868
9. AGE (If years last birthday) 87 yrs
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Prince Geo. Co. [illegible]
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME unknown St. Clair
14. MOTHER'S MAIDEN NAME Katherine Tennyson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) no
16. SOCIAL SECURITY NO. no
17. INFORMANT Address St. Clair [illegible]t [illegible] Chestertown, Md near Tolchester

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral thrombosis — INTERVAL BETWEEN ONSET AND DEATH: week
DUE TO (b) Arteriosclerosis — several years
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that I attended the deceased from Jan. 19 53 to August 24 1956, that I last saw the deceased alive on August 23 1956, and that death occurred at 12 noon from the causes and on the date stated above.
ACTUAL SIGNATURE Willard F. Smith M.D. ADDRESS (Street, city or town, state) Rock Hall, Md. DATE SIGNED 8/24/56
PHYSICIAN'S NAME (Type) Willard F. Smith Rock Hall, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF 8/27/56
22c. NAME OF CEMETERY OR CREMATORY Loudon Park Cem.
22d. LOCATION (City, town, or county) (State) Baltimore Maryland

23. FUNERAL DIRECTOR'S SIGNATURE J. Willis Wells ADDRESS Chestertown, Md.
24a. REC'D BY REGISTRAR DATE 8/27/56
24b. REGISTRAR'S SIGNATURE [illegible] Burgess

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08386

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 201

1. PLACE OF DEATH a. COUNTY: Kent — MARYLAND — 8411

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural Kennedyville Rutmore Park

c. LENGTH OF STAY IN 1b: 1 day

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Kennedyville

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Delaware b. COUNTY: Newcastle

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Wilmington

d. STREET ADDRESS: 3101 Van Buren

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First HOWARD Middle R Last McCLURE JR.

4. DATE OF DEATH: Month 8 Day 19 Year 1956

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 10-12-1934

9. AGE (In years last birthday): 21 yrs. IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Apprentice Florist

10b. KIND OF BUSINESS OR INDUSTRY: Retail Florist

11. BIRTHPLACE (State or foreign country): Delaware

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Howard R. McClure, Sr

14. MOTHER'S MAIDEN NAME: Isabelle Pierson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no

16. SOCIAL SECURITY NO.:

17. INFORMANT: L. F. Livingston Address: Carlton Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Drowning — INTERVAL BETWEEN ONSET AND DEATH: short time

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.): Drowned while swimming after object thrown on 8/19/56 in Sassafras River near Rutmore Park

20c. TIME OF INJURY Hour 12 ☒ a.m. ☐ p.m. Month, Day, Year: 8/19 1956

20d. INJURY OCCURRED While at work ☐ Not while at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Sassafras River

20f. (City or town) Rural (County) Kent (State) Md

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Robert W. Farr M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

EXAMINER'S NAME (Type): ROBERT W. FARR

DATE SIGNED: 8/21/56

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 8-22-56

22c. NAME OF CEMETERY OR CREMATORY: Chesslawn Memorial Park

22d. LOCATION (City, town, or county) (State): Townsend Delaware

23. FUNERAL DIRECTOR'S SIGNATURE: Edward A. Kaur ADDRESS: Millington Md.

24a. REC'D BY REGISTRAR DATE: 8/27/56

24b. REGISTRAR'S SIGNATURE: E. Leonard Jones

TO COUNTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8403

CERTIFICATE OF DEATH

68387

Reg. Dist. No. 202

1. PLACE OF DEATH
a. COUNTY: Kent — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chestertown
c. LENGTH OF STAY IN 1b: 6 Mo.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 532 Cannon St.

2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Kent
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chestertown
d. STREET ADDRESS: Scott Pt.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First [illegible] Middle [illegible] Last [illegible]

4. DATE OF DEATH: Month Aug. Day 25 Year 1956

5. SEX: F.
6. COLOR OR RACE: W.
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Sept. 9, 1876
9. AGE (In years last birthday): 79 yrs.
IF UNDER 1 YEAR: Months ___ Days ___
IF UNDER 24 HRS: Hours ___ Min ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housekeeping
10b. KIND OF BUSINESS OR INDUSTRY: home
11. BIRTHPLACE (State or foreign country): Worton, Kent Co. Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Daniel Younger
14. MOTHER'S MAIDEN NAME: Mary Coleman

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service): ---
16. SOCIAL SECURITY NO.: none
17. INFORMANT Address: Mrs. Joseph Long, Chestertown, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Terminal bronchopneumonia —
DUE TO (b): Stroke (hemiplegia) and
DUE TO (c): arterial hypertension

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 331X

INTERVAL BETWEEN ONSET AND DEATH
(a) 6 days
(b) 4 & 6 months
(c)

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month Day Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 7/12, 1956, to 8/26, 1956, that I last saw the deceased alive on 8/26, 1956, and that death occurred at 10:30 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Robert W. Farr M.D.
ADDRESS (Street, city or town, state): Chestertown, Maryland
DATE SIGNED: 8/28/56

PHYSICIAN'S NAME (Type): Robert W. Farr, M. D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Aug. 29/56
22c. NAME OF CEMETERY OR CREMATORY: Union Cemetery
22d. LOCATION (City, town, or county) (State): Worton, Kent Co. Md.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Marvin V. Williams, Chestertown, Md.
24a. REC'D BY REGISTRAR DATE: Aug. 30-1956
24b. REGISTRAR'S SIGNATURE: Clara L. Burns

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH--BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 18388

1. PLACE OF DEATH a. COUNTY: Kent 8412 — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Galena Rural
c. LENGTH OF STAY IN 1b: 2 months
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address):

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Pennsylvania — b. COUNTY: Delaware
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Drexel Hill
d. STREET ADDRESS: 728 Edmonds Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First BRUCE Middle EMILE Last MORLOCK
4. DATE OF DEATH: Month Aug Day 3 Year 1956
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Aug 29, 1950
9. AGE (In years last birthday): 5 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Pennsylvania
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: George A. Morlock
14. MOTHER'S MAIDEN NAME: Jean Graham
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: George A Morlock, Address: Drexel Hill Pa

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Probable drowning. — INTERVAL BETWEEN ONSET AND DEATH: a few minutes
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):
799.0

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II as appropriate): Found in water after being missed
20c. TIME OF INJURY: Hour 4 p.m. Month, Day, Year: 8/3 1956
20d. INJURY OCCURRED While at work ☐ Not while at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): home
20f. (City or town): Galena (County): Kent (State): Md

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Robert Fark M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
EXAMINER'S NAME (Type): ROBERT W. FARK
DATE SIGNED: August 3, 1956

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Aug 7 1956
22c. NAME OF CEMETERY OR CREMATORY: Valley Forge Memorial
22d. LOCATION (City, town, or county): Phila. (State): Pa.
23. FUNERAL DIRECTOR'S SIGNATURE: Edward Pellow ADDRESS: Millington Md
24a. REC'D BY REGISTRAR DATE: 8/8/56
24b. REGISTRAR'S SIGNATURE: Elizabeth J. Mumford

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Give pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8404

CERTIFICATE OF DEATH

8389

Reg. Dist. No. 282

1. PLACE OF DEATH
a. COUNTY: KENT
MARYLAND

2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Queen Annes

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CHESTERTOWN
c. LENGTH OF STAY IN 1b: 2 days

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural - Chestertown

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Kent & Queen Annes

d. STREET ADDRESS:

e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print): First JOHN Middle F. Last NEWCOMB

4. DATE OF DEATH: Month AUGUST Day 11 Year 1956

5. SEX: MALE

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 4/19/1884

9. AGE (In years last birthday): 72 yrs

IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farming

10b. KIND OF BUSINESS OR INDUSTRY: Farm

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: James Newcomb

14. MOTHER'S MAIDEN NAME: Mr Jennie Diehl

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service): NONE

16. SOCIAL SECURITY NO.: 218-30-0824

17. INFORMANT: Walter Hadaway
Address: Chestertown, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Tetanus — INTERVAL BETWEEN ONSET AND DEATH: 3 days

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Laceration on left index finger — 8 days
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): cut finger while moving grain

20c. TIME OF INJURY Hour: o. m. / p. m. Month, Day, Year: 8 3 1956

20d. INJURY OCCURRED While at work ☒ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Home

20f. (City or town) (County) (State): Chestertown Kent Md

21. I certify that I attended the deceased from 8/9, 1956, to 8-11, 1956, that I last saw the deceased alive on 8-11, 1956, and that death occurred at 12:00 M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Robert W Farr M.D.
ADDRESS (Street, city or town, state): Chestertown, Md
DATE SIGNED: 8/11/56

PHYSICIAN'S NAME (Type): ROBERT W. FARR

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 8/13/56
22c. NAME OF CEMETERY OR CREMATORY: Wesley Chapel
22d. LOCATION (City, town, or county) (State): Rock Hall, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Edgar L. Lowe
ADDRESS: Church Hill, Md.

24a. REC'D BY REGISTRAR DATE: Aug. 14-56
24b. REGISTRAR'S SIGNATURE: Clara L. Barnes

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8405 **CERTIFICATE OF DEATH**

Reg. Dist. No. 202 — 8390

1. PLACE OF DEATH
a. COUNTY: Kent — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chestertown
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: Kent & Queen Anne Hospital

2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Kent
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chestertown
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Ellsworth — Middle — Last Smith

4. DATE OF DEATH: Month Aug. — Day 9, — Year 1956

5. SEX: male

6. COLOR OR RACE: colored

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: July 8, 1888

9. AGE (In years last birthday): 68 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY: various

11. BIRTHPLACE (State or foreign country): Kent Co. Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Isaac Smith

14. MOTHER'S MAIDEN NAME: Catherine Toomey

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 217-16-9583

17. INFORMANT: Mrs. Eleanor Murray — Address: Calvert St. Chestertown, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cachexia — INTERVAL BETWEEN ONSET AND DEATH: 6 months

DUE TO
(b): Carcinomatosis probably primary in colon or Rectum — at least 6 mos.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Arterial hypertension with failure - several years

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 4/18 19 56 to 8/9 19 56 that I last saw the deceased alive on 8/9 19 56, and that death occurred at 1:30 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: Robert W. Farr M.D. — ADDRESS (Street, city or town, state): Chestertown Md. — DATE SIGNED

PHYSICIAN'S NAME (Type): Robert W. Farr - Chestertown, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Aug. 11, 1956

22c. NAME OF CEMETERY OR CREMATORY: Janes (Col.) Cem.

22d. LOCATION (City, town, or county) (State): Chestertown, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: J. Willis Wells — ADDRESS: Chestertown, Md.

24a. REC'D BY REGISTRAR: Aug. 11-1956

24b. REGISTRAR'S SIGNATURE: Clara L. Barnes

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8406 CERTIFICATE OF DEATH

08391
Reg. Dist. No. 2021

1. PLACE OF DEATH
a. COUNTY Kent — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown
c. LENGTH OF STAY IN 1b 3 1/2 hrs
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kent & Queen Annes Hop

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland
b. COUNTY Kent
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Millington
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First: Baby Middle: Girl Last: TEAT

4. DATE OF DEATH Month: August Day: 17 Year: 1956

5. SEX Female

6. COLOR OR RACE Colored

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH 8/16/56

9. AGE (In years last birthday) yrs.

IF UNDER 1 YEAR: Months — Days — Hours 31 — Min. 35
IF UNDER 24 HRS.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Maryland

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Charles Edward Teat

14. MOTHER'S MAIDEN NAME Sarah Drucilla Tiller

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Address: Sarah Teat Millington, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Birth injuries, probable intra cranial — INTERVAL BETWEEN ONSET AND DEATH

760.0

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b) Hemorrhage, anoxia (Delivery time about 5-8 min) — 31 hours

DUE TO (c) Excessive size 12# 11oz (EDC Aug 20 1956)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

Strictor palsy - left arm (Suction punctures noted in Spleen)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 8-16, 1956, to 8/17, 1956, that I last saw the deceased alive on 8-17, 1956, and that death occurred at 8:45 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE Robert Warr M.D. ADDRESS (Street, city or town, state) Chestertown, Md DATE SIGNED 8/17/56

PHYSICIAN'S NAME (Type) ROBERT WARR

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial

22b. DATE THEREOF Aug 19 1956

22c. NAME OF CEMETERY OR CREMATORY Mt Pleasant

22d. LOCATION (City, town, or county) (State) Chestertown Md.

23. FUNERAL DIRECTOR'S SIGNATURE Edward Tilghman ADDRESS Millington Md

24a. REC'D BY REGISTRAR DATE Aug 20-56

24b. REGISTRAR'S SIGNATURE Clara L. Barnes

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

68392

8413

CERTIFICATE OF DEATH

Reg. Dist. No. 201

1. PLACE OF DEATH
a. COUNTY: Kent — MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland b. COUNTY: Kent

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Coleman's Corner

c. LENGTH OF STAY IN 1b: Life

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Coleman's Corner near Still Pond

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: near -- Still Pond, Md.

d. STREET ADDRESS:

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Phillip Middle: Lost: Wright

4. DATE OF DEATH: Month: Aug. Day: 2, Year: I956 19

5. SEX: Male

6. COLOR OR RACE: colored

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Nov. II, I867

9. AGE (In years last birthday): 88 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Gardner & Farmer

10b. KIND OF BUSINESS OR INDUSTRY: Laborer

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Phillip Wright

14. MOTHER'S MAIDEN NAME: Mary Jane Wilson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: Don't know

17. INFORMANT: Mrs. Lillian Ringgold Address: Coleman's Corner Still Pond, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Bronchitis. — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) Caused by cold.

DUE TO

(c) Effusion

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): not any

20f. (City or town) (County) (State): Kent Md

21. I certify that I attended the deceased from July 31, 1956, to Aug 2, 1956, that I last saw the deceased alive on Aug 1, 1956, and that death occurred at 1 P. M. from the causes and on the date stated above.

ACTUAL SIGNATURE: L. P. Atwell M.D. ADDRESS (Street, city or town, state): Still Pond Md. DATE SIGNED

PHYSICIAN'S NAME (Type): L. P. Atwell - Still Pond, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 8/5/I956

22c. NAME OF CEMETERY OR CREMATORY: Coleman's Cem.

22d. LOCATION (City, town, or county) (State): Coleman's Corner Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: J. Willis Wells ADDRESS: Chestertown, Md.

24a. REC'D BY REGISTRAR DATE: 8/4/56

24b. REGISTRAR'S SIGNATURE: E. Kennard Jones

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4) 15M 9/55

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